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ABSTRACT

Based on selected reading of the literature on medical anthropology and the sociology of modern and traditional system integration in other societies (developing and developed), this paper argues that state heteronomy is patently contraindicated, yet inevitable, should the funding and power structure behind Western health care systems be formally integrated with the traditional American Indian healing system. Structured around a comparison of the similarities and differences between the two systems in order to initiate some thoughts about etiology, role expectations, and situational factors that are traceable to the treatment characteristics of the two systems in question, the paper attempts to reflect strengths in the traditional healing system. Tables compare and contrast two divergent orders of information between the Western and traditional health systems. A "curing" versus "healing" model is presented in four tables that attempt to compare the two systems across causation, diagnosis, roles, and treatment processes. Excerpts from the literature which are concerned with traditional and modern interrelationships from a world-system perspective are presented to convey some of the multiple dimensions of medical pluralism. The paper also discusses non-medical interventions and the destructive aspects of large-scale educational efforts to incorporate the traditional into the modern system. (Author/CM)

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TRADITIONAL HEALING AND WESTERN HEALTH CARE:

A CASE AGAINST FORMAL INTEGRATION

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TRADITIONAL HEALING AND WESTERN HEALTH CARE: A CASE AGAINST FORMAL INTEGRATION

That which constitutes effective public health care is a highly ambiguous matter. The generic conception of health care delivery in Western society is based on a single legal, educational and treatment system. Leslie (1980) describes this system as "a bureaucratically ordered set of schools, hospitals, clinics, professional associations, companies and regulatory agencies that train practitioners and maintain facilities to conduct biomedical research, to prevent or cure illness and to care or rehabilitate the chronically ill." Traditional healing systems (homeopathic) have focused themselves outside the modern medical, or in current sociological terms, cosmopolitan medicine. Folk medicine has largely been ignored, or when not ignored, derogated as a curiosity, a fringe medicine, quackery and superstition.

Today, the devaluation of natural providers and folk systems is being gradually reversed as the holistic health movement emerges with greater intensity. "Unorthodox" theories of illness and methods of treating American Indians are currently enjoying popular attention and Indian spokesmen are calling for "method of blending traditional and modern forms of medicine" (NIHB Health Reporter, 5:1980, p.8ff; NIHB, 1979, p. 21; AAIP newsletter, 9:1980).

Those who would integrate Western and traditional health care systems, whether identified with Western professional ideology, or biased sympathetically to Indian culture or both, are granted the altruistic desire to reach greater numbers of Indian people with improved health care. Yet, they seem to have a practical rather than an ideological concern for treatment approaches and see nothing in-

consistent or potentially dangerous in attempting to blend modern and traditional approaches together.

Increasingly, recommendations are calling for expanded federal intervention in the official recognition and training of traditional healers. It is as though everyone has forgotten the bureaucratic intrusion lessons of the past. Somehow, dominant and established service systems are supposed to behave differently today and government intervention is called upon solely to "bridge the gap". Little enough recognition is given to the cultural context in which modern and traditional medicine function -- and less effort yet seems to be made to place these two health systems in their socio-political and economic context. The unforeseen consequences of not taking a critical look at a premature effort towards integration of two distinct health delivery systems could signal a co-opted alteration at best -- or a premature end at worst -- to a delicate system of healing that is only now finding its way back into the Indian way of life with the vigor it once knew. It may well be that traditional healing among Indians is relatively intact precisely because that system has not been tampered with up to now.

PURPOSE

Until recently, the well-intentioned social and medical programs imposed by federal and state agencies upon Indian people have been consistent in two respects: (1) they have been insensitive to Indian cultural values, and (2) they have undermined the traditional authority of community leadership by

assuming responsibilities historically held under local control (Topper, p.76). The theme throughout this paper will argue that state heteronomy* with its gradual and cumulative bureaucratic requirements appropriate and perhaps necessary to the one system of health care -- performance requirements, standards, evaluation criteria, and administrative accountability -- is patently contraindicated, yet inevitable, should the funding and power structure behind Western health care systems be formally integrated with the traditional.

McDonald (1980) cites numerous studies to demonstrate that knowledge is not exclusively Western. Most studies she reviews give minimal attention and assumed inferiority to folk healing, while focusing concern on the scientific progress of medicine. As a result of this skewed perspective she cautions, "any future attempt to integrate a native healing system into a modernizing one would be well-advised to consider the characteristics of the native system, for more practical and mundane reasons" (1980, p. 103).

This paper is based on selected reading of the literature on medical anthropology and the sociology of modern and traditional system integration in other societies (developing and developed). The experiences noted in the former, or third-world countries, seem to have special significance for Indians in the United States because their rural resource base, socio-economic status, and political histories have so much in common. Secondly, the paper is structured around a comparison of the similarities and differences between the two systems in order to initiate some thoughts about itiology, role expectations, and situational factors that are traceable to the treatment characteristics of the two systems in question.

*Heteronomy here refers to the institutionalized form of state intervention to remove from both an occupation and its clients (to a greater or lessen extent) the authority to determine the content and manner of practice.

The tables attempt to reflect strengths in the traditional healing system to counter the general lack of intellectual reciprocity concerning folk medicine on the part of Western trained providers (McDonald 1980; Kleinman 1980, p. 56-57). More importantly, they are intended to compare and contrast two divergent orders of information between the Western and traditional health systems. The social reality of reservation life varies considerably from that of urban America. Kleinman could have had the Indian in mind when he stated;

> "The change from old to new social forms holds the same profound implications for health care systems as for other cultural systems. In such modernizing societies, one finds social realities that are a strange amalgam of modern and traditional beliefs, values, and institutions held together in varying patterns of assimilation, complementarity, conflict, and contradiction. Since modern medical ideas and practices are often at the tip of the wedge of technology introduced during the modernization process, it is not surprising that health care systems provide some of the sharpest reflections of the tensions and problems of social development. (Kleinman 1980, p. 37)

TWO ORDERS OF INFORMATION

While the total health system is properly considered on a continuum from folk to modern, two divergent orders of information can be separated between Western and traditional practices. The "curing" vs. "healing" model described below admittedly seems to be a more useful tool for contrasting the two systems than for teasing out similarities. Further, the model over-simplifies in that it fails to take into account exceptions to the rule or to reveal the many complexities and nuances of each system within itself. Nevertheless, the chief goals and related activities of modern and traditional approaches can be artifically separated from each other while keeping in mind that the totality of the interrelationships is the health care system that most Indians acknowledge. The model is presented in four tables that attempt to compare the two systems across causation, diagnosis, roles, and treatment processes.

TABLE 1

COMPARISON OF CAUSATION FACTORS

WESTERN HEALTH CARE "HOW"	TRADITIONAL HEALTH CARE "WHY"
1. Processual Explanations	1. Etiological Explanations
• Based on concepts of instrumental causality	• Based on concepts of ultimate causality
• Body-state imbalance (focus: the body) e.g., germ theory	• Patient out of harmony with nature. e.g., spiritual life and social disturbance
• Theory relates to effect of illness on body (illness results from a physiological disturance of bodily processes)	• Theory relates to reason for the occurrence of illness (illness results from individual lack of harmonious relationships)
• Focus: emperical data surrounding illness of patient	• Focus: metaphysical beliefs and strengths of patient
2. Internal Etiology	2. External Etiolcgy
• Natural or chance causes	• Intervention of supernatural powers (other's retribution or retaliation)
• Explanations in impersonalistic, systemic terms (imbalance of basic body elements)	• Non-human (supernatural leaves little room for accident or chance)
• An equilibrium model; dichotomy is health vs. illness	• Example: "Not Navajo Life" dichotomy is "good life vs. bad life."
3. Levels of Causality	3. Levels of Causality
• Instrumental or immediate cause	• Causes on a continuum (instrumental causes to ultimate causes)

Table 1 describes two aspects of every illness in which people are generally concerned: "how" did I get sick, and "why" did I get sick? (Douglas, 1969).[1] Scientifically oriented health care workers (HCW)[2] typically deal with "how" kinds of questions -- symptoms and processual issues aimed at restoring body balance. People seek out professional providers to alleviate stress and pain. They expect and pay for the latest technical materials and advice to reduce or eliminate symptomatic causes for their discomfort.

When symptomatic relief is not forthcoming or, occasionally, when answers to "why is this happening to me" becomes relevant, traditional health care providers are sought by many Indian people. This process is similar to non-Indians turning to their spiritual advisors seeking personal answers to the transcendental concerns that personally touch their lives.

Traditional healers work less with technique and technical healing aides than they do with spiritual power. Supernatural power is perceived as emanating from both consumate good in the world as well as consumate evil. Ultimate causation of personal stress -- physical and mental illness among them -- is not attributed to instrumental reasons, e.g., germ theory, loss, and internal feeling states. Rather, causal factors are ascribed to thoughts, feelings and behaviors destructive to internal harmony (Topper and Begaye,

1. Douglas (1969) and others have identified some of the distinguishable clinical tasks in the curing and healing roles. Kleinman (1980) offers yet a sharper distinction in reference to "curing of disease" and "healing of illness" (p. 82).

2. The abbreviated HCW is taken from the definition of the term "modern health care worker" by Joseph Westermeyer, M.D. (1977). It includes physicians, dentists, social workers, nurses, psychologists, and similarly trained practitioners whose powers to treat are based on the scientific method, demonstrated knowledge and skills, licensure by the state, and certification by peer professionals.

p. 85 ff; Leighton and Leighton). Among the Navajo, for example, the dichotomy is not between mental health and mental illness, but between living "bad life" (a form of "not Navajo life") and "good life." This underlying spiritual imbalance requires treatment focused upon restoration of "good life," not symptomatic cure.

For Indian people, the illness-health continuum is grounded in such cultural perceptions of the world. How, then, are these world views to be integrated with the precise technology and clinical reality of the dominant health care system? While Western services provide excellent descriptive categories and exact instrumentation, they are judged poor in offering explanatory models of causation.

TABLE 2

COMPARISON OF DIAGNOSES

WESTERN HEALTH CARE "HOW"	TRADITIONAL HEALTH CARE "WHY"
1. Diagnosis attempts to understand <u>How</u> patient became ill	1. Diagnosis aimed at understanding <u>Why</u> patient became ill
• Evidence related to picking-up signals from the body (sumptoms) - signs and symptoms, external manifestations of illness measured as deviations form normal	• Evidence related to reasons for spiritual imbalance
• Validation: degree of deviation from "normal" body functioning, observed, reported and inferred from somatic evidence	• Validation: by seer, through devination; secondary meanings inferred from situational evidence
• Diagnosis related to empirical evidence and symptomatic treatment	• Diagnosis related to etiological factors of a metaphysical order
• Diagnosis largely depends upon what patient reveals; extensive facesheet and narrative at intake; psychological tests	• Diagnosis already known (often the less said by the patient the better); traditional healers speak with the patient's spirit
• Diagnostic bias in favor of illness, e.g., what is wrong with this person (weakness)	• Diagnostic bias is on the internal/spiritual state, e.g. does patient desire to harmonize self with the Great Spirit (strength)
2. Diagnosis involves <u>labeling</u>	2. <u>No labeling</u> -- if traditional healer agrees to intervene, patient is accorded maximum respect (sincerity is recognized)
• iatrogenic illness is a risk	• protocol important
• stigma	• Three criteria: 1) faith in "supernatural" powers, ceremony, yourself, and God; 2) respect for yourself, your people, for all people; 3) love for your patient. (Stevens-Navajo)

Table 2 differentiates a few of the many ways in which two kinds of data are perceived and acted upon in arriving at diagnoses. As in causality, modern HCW look to acute and chronic pathological agents or life stresses to explain "how" disorders materialize. Traditional healers seek diagnostic criteria that have ultimate etiologies as the source, i.e., fundamental explanations of "why" the condition has occurred. Of course in actual practice, both systems are divided along more than this one diagnostic axis.

Levy-Bruhl, as quoted in Morley (1978), contrasted the fundamental diagnostic differences between traditional healers and western trained practitioners. He stated:

> - - - the reality in which primitives move is itself mystical. There is not a being, not an object, not a natural phenomenon that appears in their collective representations in the way that it appears to us. Almost all that we see therein escapes them, or is a matter of indifference to them. On the other hand, they see many things of which we are unaware. (p. 7)

Perhaps at no sharper intersect do the traditional Indian culture and western health care collide than in the diagnostic labeling process that takes place in offices, hospitals and clinics. The preoccupation with labeling results in socially created reality for the purpose of arriving at a prescription to treat "how" explanations of disease and disability. Goffman (1961), Szasz (1961), Laing (1970) and others have expressed interest in the ways in which Western health care can be used for political purposes. To make their point, they all contrast "unreal" mental with "real" physical disease. The diagnostic measurements, anatomical and physiological testing, and experiments applied to physical sickness are replaced with the mental health practitioner's judgment as to deviancy without reference to the value system of the diagnosed person. The political dangers of

the implication of their argument for Indian peoples are those of (1) stimulating continued success in the perpetuation of self-fulfilling prophecies ("the drunken Indian" and other stereotypes); (2) introducing non-Indian cultural norms through inappropriate application of Anglo-western theory to Indian behaviors, (3) perpetuating a climate for low self-esteem; and (4) contributing further to tribal and cultural dis-integration. If the HCW concern ultimately is with mutually-qualifying interaction between the individual and his milieu, successful therapy is more likely to occur when it is culturally syntonic rather than diagnosis-specific (Araneta, 1977, p. 69).

How, then, does one go about integrating into traditional healing world views a system of diagnosis whose iatrogenic labeling (Illich, 1976, pp. 89-90) brands the patient forever with a permanent stigma? The traditional system, in response to concerns of ultimate causation, attempts to reverse the degradation to the patient's identity by telling him he is now in harmony with life. The Western system, in response to concerns of curing the observed symptoms, applies an adhesive label that renders the patient forever as an ex-offender, ex-alcoholic, and ex-mental patient. Implicit in traditional diagnosis is the expectation that the patient assume primary responsibility for cause, effect, and change of his condition; just as implicit, Western diagnosis tends to replace this personal responsibility with maintenance, management, check-ups and follow-through by a professionally staffed agency.

TABLE 3

ROLE COMPARISONS

WESTERN HEALTH CARE "CURERS"	TRADITIONAL HEALTH CARE "HEALERS"
1. Primary role is that of technician (restoring "normal" body functions)	1. Primary role is that of mediator (between immediate effect and ultimate cause)
• Deals with illness condition	• Deals with illness situation
• Uses specialized knowledge	• Uses supernaturally granted power
• Is related to curing	• Is related to healing
• Is that of the "doer"	• Is that of intermediary and facilitator
2. "Curers" work with specialized knowledge and techniques	2. "Healers" broker with supernatural power primarily; also has knowledge of ritual, herbs, etc.
• Open to anyone who aspires to acquire the knowledge (self-selecting)	• Reserved for a few who are chosen to fulfill a specific purpose in life (an extra-human process; a "gift")
• High level of tolerance for cognitive dissonance required to maintain divergent roles of "curer" and scientist	• Sometimes "how" techniques are used, but their purpose is to reestablish inner harmony
• May devote life to continued learning, searching for new methods	• Must devote life to continued learning. Searching for old ways (much that was known has been lost)
3. Role focus: to reduce or eliminate pain	3. Role focus: to provide significance and meaning to pain and suffering (interprets its meaning and necessity)
• Utilizes methods of patient control to eliminate pain	• Helps person in pain or stress to take responsibility for his experience
• Basically supportive, as illness is often perceived as environmental (epidomiology), accidental, or beyond patient's personal control	• Basically confrontive (maximum support but maximum confrontation, i.e., "you did it! You choose to be this way -- you can change it"!

4. Roles formalized through credentialing and/or licensing	4. Roles sanctioned through community acceptance
• Licensure/certification demonstrates competency (professional review)	• Competency evaluated by tribal community served
• Patient goes to the "curer" -- turns trouble over to the professional	• Healer is an instrument (turns professional paradigm around as healer puts responsibility on patient)
• Roles are standardized by bureaucratic organization	• Roles are standardized by cultural tradition
• Role requires adherence to professional codes, public law, policies to protect self and patient	• Role and personal protection is derived from following the "Indian way" completely and maintaining personal cleanliness (e.g., non-smoking, non-drinking)

Table 3 draws comparisons and distinctions between the "curing" role of HCW and the "healing" role of Indian medicine people. Similarities are noted principally at obvious levels: both are helpers; both undergo rigorous training and maintain a continuous learning stance; both rely on external resources, such as pharmaceuticals and herbal medicines; both are licensed, credentialed, or otherwise sanctioned by their communities; and both represent complex systems.

It is at the juncture of role dissimilarity where integration of the two systems becomes difficult, if not impossible. Prominent differences include etiology, teleology, and methodology. One system looks to poverty, improper sanitation, accidents, low self-esteem and genetics among the conditions which account for specific role prescriptions. The other designs role responses to deal with illness situations involving "sorcery or witchcraft, breach of taboo, object intrussions, soul loss, soul possession, ghost sickness and, of course, natural causes" (Joe, p. 142).

Purposes for which the "curer" and the "healer" apply their skills and knowledge is considerably divergent. The HCW is trained to restore health or maximize living potential through techniques which eliminate virus, increase body resistance, develop insight, improve diet, and alleviate stress. This training is scientifically oriented and ethnocentric, holding to Anglo-European cultural values that "must categorically deny the existence of supernatural influences," (Ruiz and Langrod, 1977, p. 93). The medicine person believes that all mankind has the purpose of living harmoniously with God, his fellow man and the natural elements. He believes that each person was born to fulfill an individual purpose as well. When illness or misfortune is experienced, through personal discord and responsibility, it becomes the "healer's" role to mediate between that person and constructive supernatural forces to restore harmony to the situation. As competence is often compared between one physician, psychotherapist, nurse or social worker and another, Indian families, too, weigh the relative merits between singer ceremonials and hand trembler diagnostics. But roles <u>across</u> systems seem not to be comparable. Different methods are employed to accomplish different purposes for different reasons.

TABLE 4

COMPARISON OF PROCESSES

WESTERN HEALTH CARE ACTIVITIES	TRADITIONAL HEALTH CARE ACTIVITIES
1. <u>Treatment</u> focused upon body or mind manipulations to establish normal mental or physical functioning • Involves concepts of ethno-anatomy, ethno-physiology, epidemiology, prevention • Activities very flexible and pragmatic (new approaches and new practices readily accepted)	1. <u>Treatment</u> aimed at marshalling of supernatural powers to intervene in spiritual situation first, then mind and body dysfunction • Involves concepts of cosmology religion, ethics, personal responsibility • Activities may include ready incorporation of modern technical knowledge to treat instrumental causes, but "life view" and historical "thoughtways" remain fixed to treat ultimate causes.

• Shared activities with supervisors, consultants, peers (inter-agency collaboration)	• Activities considered very personal by each healer. "Nobody can tell you what I do -- that's mine" (Rolling Thunder)
• Often correlates with "don'ts" Processes include doing <u>to</u> people	• Often correlates with "do's"! Process include doing <u>with</u> people
• Treatment requires that patients give the <u>professional</u> their trust -- necessary to "establish a relationship." Patient gives responsibility for change to the professional	• Treatment requires that patients believe in the <u>medicine</u>; that you "put" the disease there and you have the responsibility to "take it away." Healer will not take on patient's responsibility, patient's illness, or patient's growth
• Curers tend to mystify and expropriate the power of the individual to heal himself and shape his own environment	• Healers contend only God can intervene and this will not happen unless patient <u>asks</u> first
• Task of getting well belongs to professional providers, an anonymous agency, and the insurance company	• Task of getting well belongs to the sick! Hope and positive attitude are supports.
• Prevention focus requires intrusive techniques	• Interference in the personal lives of others is contrary to the Indian value system
2. <u>Methods</u> include applications of materials into or onto the body	2. <u>Methods</u> include ritualized prayers and actions, healer acts as mediator between patient, his group and the supernatural world
• Intent is to reestablish normal functioning	• Intent is to reintegrate the individual into his total universe
• Form includes medication, diet, surgery, drugs, clinics	• Form includes correct and appropriate combinations of chants, sings and ritual, often to go along with specific herbal remedies; may also include sandpaintings, incense, and sweatbaths.
• Resources include Government funding, University systems for professional production, technological research and a vast consuming public	• Resources include the patient's belief and the Great Spirit primarily. Reestablishing broken relationships within the group or extended family is also a considerable resource

- Minimal hierarchy of practitioners: example: Among the Navajo:
  1. Singers (Specialists)
  2. Diagnosticians (Shamans)
  3. Hand tremblers
  4. Laymen (e.g., every Navajo man and woman performs some ritual prayers, songs and legends (Leighton & Leighton)

3. Language highly technical

- Frequently increases dependence of patient on the care of an elite profession
- Jargon of multiple disciplines, as well as that of the bureaucrat, adds to confusion
- Language of prayer considered as a last resort
- System designed for financial efficiency, professional reward and bureaucratic control
- Methods are compartmentalized to treat specific body or mind ailments (reductionistic); services fragmented.
- Methods separate the individual's treatment from his social nexus

4. Place where activities are performed typically include:

   1. Hospitals
   2. Clinics
   3. Offices

3. Language involves hundreds of songs full of archaic words that must be learned perfectly

- Precise tone and way of singing songs essential
- Enormous number of rules about sequence that are extremely complex and thorough
- Expressive names for offending spirits (known to all participants
- English frequently perceived as a "contrary" language
- System organized for local effectiveness, maintenance of tradition, antonomous learning, and lay control
- Methods integrate spirit, mind, and body (holistic)
- Methods require involvement and participation of social group survival and a sense of security

4. Place where activities are performed typically include

   1. Patient's home
   2. Natural surroundings
   3. Sometimes hospital or prison setting

• Sick are isolated (waiting rooms, visiting hours, appointments, etc.	• Group involvement provides motive for increased social tolerance of the troubled
• Pharmacies dispense synthetic prescriptions of multiple colors (red, blue, black, white)	• Herbs are gathered from outdoors (one color: green)
• Practice environment conducive to urban living	• Practice environment conducive to rural life styles

Table 4 compares treatment activities associated with Western and traditional healing systems. The dominant Western ideology of health care focuses upon the technical mastery of disease and stress syndromes. This is practiced to such a degree that the "mysticism" associated with what the HCW does is as incomprehensible to the patient and his family as is the mysticism surrounding the ceremonial and spiritual activities of the traditional healer.

Traditional medicine persists, in part, because of the mysticism and skepticism surrounding Western health care. Traditional reservation people are aware of the maldistribution of modern medical and human service resources, which are concentrated in large urban centers. Many others are supported in returning to traditional ways by the pan-Indian movement, the holistic health movement, and the government's current policy of self-determination.

More importantly, traditional medicine survives because it is offered in the context of cultural significance to Indian people. Each culture gives unique shape to the meaning of health and to a unique conformation of attitudes about pain, suffering, and death (Illich, p. 128). The strength of traditional Indian ways of comforting people while in stress is exemplified best in two functions

that dramatically distinguish the system from modern Western care. These are: 1) the ways in which it makes pain and death tolerable and even understandable, by integrating these experiences into a meaningful setting and context, and 2) the prominence it gives to extended family involvement and group cohesion and harmony.

Illich (1975) makes the distinction as follows:

> . . . medical civilization . . . tends to turn pain into a technical matter and thereby deprives suffering of its inherent personal meaning. People unlearn the acceptance of suffering as an inevitable part of their conscious coping with reality and learn to interpret every ache as an indicator of their need for padding or pampering. Traditional cultures confront pain, impairment, and death by interpreting them as challenges soliciting a response from the individual under stress . . . it makes pain tolerable by interpreting its necessity (p. 133-134).

The dominant American perspective on death and dying is to deny or avoid the topic as much as possible. In a study of major sociological significance on this subject, Glasser and Strauss (1965) demonstrate the many ways in which professionals receive training for the technical aspects of dying, but not on the ethics, social issues, moral and personal values associated with death. The standard mode "is a tendency to avoid contact with those patients who, as yet unaware of impending death, are inclined to question staff members; (to avoid) those who have not accepted their approaching deaths; and (to avoid) those whose terminality is accompanied by great pain" (Glasser and Strauss, p. 5).

In contrast, traditional healing has emphasized physical endurance and spiritual growth to the extent that the capacity for suffering could even be understood as a possible symptom of health among Indian people. Formal procedures for integrating this cultural world view into that of the technically managed and pain-killing viewpoint of western care, creates the risk of replacing those unique cultural

meanings of dignified suffering with the artificially prolonged and depersonalized maintenance characteristic of the dominant system.

The psychological significance of group values among Indians has not been lost to modern historians. John Bryde (1971) writes, "Indian people have a sense of togetherness, a sense of <u>being Indian</u> together that most racial groups don't have" (p. 57). Among most tribes, the kinship system is the primary identification link determining social relationship and responsibilities. The functional abilities of a person within these clan and familial structures seems essential to personal identity. ". . . If someone should get ill or become disabled, everyone is affected" (Joe, p. 143). Consequently, the ceremonials and religious lore surrounding traditional healing have an important influence on the entire household. Leighton and Leighton describe the therapeutic value of multiple participants:

> The crowd is not just a crowd; it is usually composed of all the persons who have been of importance in the patient's life--his relatives, his respected elders, the human guide-posts who have formed his orientation in the world . . . . All these people are gathered, their attention focused on the patient, bringing their influence and expectation to bear on his illness, their very presence inferring that powerful forces are working for his well being (Leighton and Leighton, p. 12).

People learn by observing the healer; they incorporate the legends with their own lives; and they use this knowledge to maintain their own harmony, taking care of their own health and contributing to the health of others. These activities have use and value to the individual and to cultural and group maintenance. They are undertaken with the competence of generational development and enjoyed for their own sake.

How does one go about integrating this group system of care into the individual process of modern health care? The Western system separates the "primary patient" from others about him, places the patient in isolation wards, and often restricts child visitors. It replaces family strength and responsibility with professional expertise and bureaucratic control. Finally, it replaces autonomous activity and spiritual belief with consumer products to be purchased, competing professional skills in the market place, and a belief in scientism.

IMPLICATIONS FOR HEALTH CARE POLICY AND SERVICE DELIVERY

In arguing against integration of the two systems of health care, differences have been emphasized. This contrast is not to suggest that the two systems are necessarily competitive. To the contrary, they are complementary. Less technically sophisticated cultures historically have incorporated empirically validated techniques and integrated new knowledge into their healing practices (Morley, p. 16). Certainly from the patient's point of view, the two orders of explanation are complementary rather than alternative approaches to his treatment as he seeks relief from both curer and healer.

Asking Indian people to choose between the two systems is irrelevant. They will continue to utilize both. Assuring the Indian patient of his historical right to understand his plaintive "why did this happen to me?" in his unique spiritual and cultural realm is not irrelevant.

Lowie appropriately sums up the essence of the religious factor:

> Science has achieved remarkable results, both practical and theoretical, but it has not made man a superman; so long as the enormous chasm yawns between man's rational control of nature and his biologico-psychological drives, there will still be room for belief in a Providence that grants not mere comfort,

> but security-- not mere probability, but uncertainty. Religion and science thus perform different functions in the life of man, and it is not necessary that either should interfere with the other (Lowie, 1963, p. 542).

The critical factor, from this perspective, becomes a matter of how and to what extent the two systems should be merged. The co-existence, complementarity and integration of the two systems at the service delivery level is more or less an accepted reality. It is when formal models of integration are proposed, i.e., when a centrally directed bureaucratic system is suggested as the suitable organizational form for financing, monitoring, and evaluating this fusion of systems, that the multiple dimensions of serious and perplexing problems arise. Questions develop;

- around what is traditional healing, who provides this service, and who decides these issues;
- around the exploitive experience of Indian peoples in the past, when well-intentioned (and some not-so-well-intentioned) changes and controls were thrust upon Indian world views and cultural realities;
- around the similar experiences of traditional healers in other countries as state controlled health services were introduced;
- around the unique experiences of American Indian people vis a vis the United States Public Health Service over the past twenty-five years, that suggest the limited appropriateness of comparison to folk medicine experiences in other countries;
- and around the many manpower dilemmas, including training, and the degree to which many Indian leaders resist becoming involved.

Professional and Personal Bias

The administrator of health care is not served by the uncritical adoption of the stereotyped perspective of orthodox practitioners. Although holistic health advocates have made stries toward acceptance of traditional healing concepts, the general perception of what a "medicine man" does is still closer to the pejorative image of the movie cliche than to that of a true spiritual healer. Local decisions on how a traditional healer's services might be utilized should not be determined by the scientific viewpoint alone. Nor should policy inquiry be rushed into with premature acceptance of every "fringe" and "marginal" practitioner who presents himself as a traditional healer.

Lessons of the Past

Few students of American Indian history -- and few Indians -- would disagree that Indian cultures have waned more than they have waxed under the reinforcement of state power over various expressions of those cultures. Unger's introduction to The Destruction of American Indian Families (1977) reminds us that the grim experience of Indian people are not relegated in time to Horseshoe Bend and Wounded Knee.

> Unwarranted and unjust governmental interference with Indian family life is perhaps the most flagrant infringement of the right of Indian tribes to govern themselves in our time and the most tragic aspect of contemporary Indian life (Unger - editor's preface - 1977)

While the Dawes era may be in the past, cultural absorption continues in more subtle fashion. For example, Singer (1977) posits three basic reasons against the use and promotion of traditional healers. Ironically, one can disagree with his premises yet agree that his views articulate valid agruments against integration. First, he considers the promotion of traditional

healers as nothing more than continued socio-economic exploitation of the "native of colonialism." His second concern is that scientific clinical base lines are replaced with cultural relativity, low-paid paraprofessionals, and "normative propositions concealing value judgements." Finally, he would resist integration on the grounds that it violates the "progress idea." This latter argument he supports with the belief that a progressive culture (Western) is advanced to the extent in which it can disengage itself from the primitive belief systems, magic, and superstitions of the traditional healer.

Taking A Lesson From World Perspectives

Rappaport and Rappaport (1981) propose an integrated system of healing modeled after reported successes of experiments in Nigeria. Unfortunately, their optimism is neither shared nor supported by sociological data which review the multiple complexities of the situation in numerous third-world and developed nations.

Of timely import, two special issues of the international journal of Social Science and Medicine are devoted to the vital political and economic issues addressing whole sets of national and international health problems that inferentially impact American Indian tribes.* These collections of scholarly works concern themselves with traditional and modern interrelationships from a world-system perspective. They examine the many ways that both approaches to health care are closely tied to the political power structures of different countries and to the interrelated problems of exploitation between core capitalist (industrialized) nations and peripheral (underdeveloped) nations.

*(Leslie, "Medical Pluralism", 1980; and Elling, "Traditional and Modern Medical Systems", 1981)

To select excerpts (below) from these papers is an admittedly argumentative ploy. Yet, in collective fashion, they do convey some of the multiple dimensions of medical pluralism and the need to disentangle the issues before presupposing that integration of traditional healing with scientific health care systems is automatically in the best interest of Indians.

On cultural hegemony in Paraguay and Mexico, Brownigg's and Dewalt's observations are noted by Elling (1980, 2, 92-93):

> Coupled with not infrequent genocide, as the massacre of the Ache, even the precarious survival of the native peoples is placed further in jeopardy. The loss is not only lives, but information. With the loss of each group of people organized as a whole culture, the species loses only its past but also alternatives for its future societies. Lost also is such knowledge as the esoteric ethnobotany of the native people, their medicines which have proved the source for hundreds of modern drugs. The depletion of cultures works very much like the depletion of a natural resource. Once gone, always gone.
>
> Dewalt found in a Mexican village that government programs and other structural changes in health facilities and services brought about a disconcerting uncertainty on the part of users of service as to what to do in the case of previously familiar diseases. In short, the power of government and control over resources brought about a new cultural hegemony in the medical sector.

On stratification, resources and the medical mix, Elling (2, 96) describes how the "medical model" supports "consonance between class and care":

> Modern medicine is technologically and scientifically based as is the industrial society itself: its knowledge is disguised as esoteric, whereas folk medicine is widely shared, it tends to be elitist and hierarchical, with physicians at the top, and even has graded hierarchy of prestige as between different kinds of physicians; with "professional" power concentrated in small numbers, it can be more easily controlled by a ruling class than can a

popularly based form of health care; its thrust is toward individual acute care and even the person tends to be atomized placing great power in the hands of the specialist expert; and it is expensive, especially its cathedrals-modern hospitals (or, as Dr. Mahler has termed them "disease palaces").

Traditional medicine by contrast, although its forms are many and it is hard to generalize, tend to be built upon accumulated understandings, rather than scientific proof (though certainly the bulk of modern medicine also shares this quality); it is more generally the province of everyone, with less concentration in the hands of experts; it is more dependent upon or works through social supports in the community; and it is relatively inexpensive.

Consider the selcted comments from several researchers on plural health systems in India:

Bhardwaj:

> Throughout the history of homoeopathy in India, it had to face incessant criticism from the "Official" allopathic (Western) system due to the alleged unscientific principles on which homoeopathy was based.
>
> ...In most other countries of the world homoeopathy either became reduced to a medical heresy or a cult after the cosmopolitan medicine absorbed what it could from it. (Bhardwaj, 1980, 214-15)

Minocha:

> The failure of modern medicine is seen to lie in the doctor's failure to appreciate what the people themselves see as their needs and in the alientation of this "Western system" from the people's cognitive categories. What the people see as their real "need" are often radically opposite what the professional doctor or engineer or social worker see as their "needs". The temptation, therefore, is to tackle the "needs" as seen, and assign the people's view to a second place, or to ignore it completely. (Minocha, 1980, 220)

Barnerji:

> ...it is particularly important to distinguish between the true clinical core of scientific medicine and the surrounding folk magic, customs, and faddism that are included in that institution of medicine. The same principles also apply to the indigenous systems of medicine just as their neglect is undesirable, so will be their romanticisation, particularly in view of the degeneration that has set in within these systems because of political and social forces as discussed.
>
> The central premise of an alternative health service system will be to start with the people instead of fitting people within a predetermined framework of health services, a framework must be designed to form a health service system which is specially tailored to suit the requirements of the people. (Banerji, 1980, 113)

Lock reports on a developed nation's (Japan) official encouragement to promote control of traditional medicine and the subsequent sacrifice of those "special features" of traditional medicine. She describes the current reassessment of this position and efforts to re-legitimize contemporary traditional practitioners:

> Current trends in Japanese society encourage the use of the traditional medical system; firstly, Japan is at present undergoing the process which is self-consicously term Nihonka (Japanization). As after other periods of drastic social change and innovation, a time of re-evaluation is occurring in which traditional aspects of Japanese culture are being actively fostered, including forms of art and physical activity which share a philosophy closely linked to that of traditional medicine. (Lock, 1980, 250)

The essential lesson from these international experiences at integration are summed-up best by Nichter: "...although cosmopolitan medicine may be seen as demonstrably effective in the short run, it is not always considered beneficial in the long run. (Nichter, 1980, 232)

NON-MEDICAL INTERVENTIONS AND UNIQUE EXPERIENCES

While the arguments against monopolization of the legal and political community against traditional practices have been consistent throughout this paper, there are unique aspects of Indian history and health care vis a vis the United States Public Health Service that require acknowledgment. It is helpful to follow those scholars who separate aspects of health care that deal directly with curative and preventative clinical tasks from interventions that pertain indirectly to health care, i.e., providing safe water supplies, enforcing laws against food adulteration, and maintaining nutritional programs, good roads and transportation.

In regards to these non-medical interventions, there is little question that considerable resources have been committed to Indian communities and that these efforts have been effective in the improvement of Indian health to a degree unknown in third-world countries. In these non-medical areas, as well as in the technical/medical care system, predominant efforts have not been to develop a new system of health care for Indians but to advance the "benefits" of the prevailing cosmopolitan system of care. Although problems persist in being greater than the resources to deal with them, primary efforts have been made to teach Indian communities how to utilize the Western system rather than attempting to change perspectives on tradition systems. The Public Health approach of the past quarter century has not had a major vested interest in changing values, imposing fees for service, or co-opting religious activity. Whether this policy of enhancing health care prevails over the advancing idea of state heteronomy as an institutionalized form of control over traditional practices remains to be seen.

MANPOWER ISSUES

Major effort to tamper with educating and training of traditional healers may prove to be the biggest folly of all. Training presumes, in the first place, that Western education can provide the means whereby traditional healers can become better at that which they are already the experts! Secondly, it presumes that organized training programs will limit themselves to "development" aspects of manpower concerns, and not encroach upon selection, utilization, and retention criteria. Yet each of these issues is as related to education/training as manpower concerns are related to the administration of health care.

Formally promoting large scale educational efforts to incorporate the traditional "healing" system into the dominant "curing" system has two interrelated and ultimately destructive aspects:

1. It compounds a basic problem of enforced dependency upon Indian people. Further indoctrination to become consumers of external supports becomes encouraged, rather than the recognition of tangible evidence of self-reliance in meeting their own health and spiritual needs in traditional ways.
2. It contributes, perhaps fatally, to further withering of the traditional way of consoling, caring and comforting people.

Taken collectively, the following quotes from contemporary traditional healers reveal something about the way in which expanded formal training programs might be measured and accepted:

> . . . we are now living in a time of young people. We will learn your education--learn it well--and use it for the good of the people. Yet many educated Indians go a different way . . .
> . . . give us a chance to rehabilitate our people--not with AA but with our spiritual way of life.
> Archie Fire Lame Deer (Sioux)

> The more the traditional ways are understood as being related to life and cultural beginnings, the more Navajo way will be preserved and healthy bodies will walk in the path of sacred corn . . .
> . . . There is some power yet among some medicine men if they use the power properly . . . but my medicine I can't give to anybody, it's mine.
> Fred Stevens (Navajo)

> My medicine is a gift I was born with. You don't learn it in six months, one year or two years. You young doctors--you learn from the book. You are a professional. Yet, people are still looking for something.
> Soloho (Hopi)

> What do I do? Nobody can tell you that. That's mine . . . There's nothing to buy--no amount of money can buy this . . . offering money is an insult . . . I have nothing to sell!
> . . . If I follow the Indian views completely, then I'm going to be protected.
> Rolling Thunder (Shoshone)

CONCLUSION

Throughout this paper, the message has been consistent: systems integration well-intentioned or not, can create as many new problems for the cultural integrity of Indian people as it may resolve old problems. The argument has been against encroachment upon traditional healing practices in official ways

that will replace them with the bureaucratic controls of modern social services and medical procedures.

Instead of puzzling over which of the two systems is appropriate to Indian people -- or how a pay-system and training regimen for traditional healers could be formalized -- public health administrators and modern HCW might puzzle over the neglected social and economic conditions which prompts Indian people to require so much attention from the public health sector beyond their own coping resources. Ultimately, the "curing" vs. "healing" mix may not alter health patterns of Indian people as much as health education, continued non-medical strategies to guard against health hazzards, and appropriationsto fund adequately the intent of legislation such as the Indian Health Care Improvement Act (PL-94-437).

As the ambiguities of Western vs Traditional approaches are unraveled, the potential impact upon a uniquely American resource should not be considered lightly.

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